HOMELESSNESS AND HEALTH

Identifying the Clinical Needs of the Homeless

Rosalyn Gambell and Nicki Cunningham
St. Michael's Hospital, Toronto, ON, Canada

ABSTRACT

Objective

Our poster presentation highlights the use of a clinical pathway specifically designed to meet the primary and psychosocial needs of the homeless and marginally housed persons who are admitted to General Internal Medicine at St. Michael's Hospital, Toronto, Ontario, Canada.

Methods

Using the Batalden Serial "V" Clinical Quality Improvement Model, a multidisciplinary team created a clinical pathway to meet the unique needs of the homeless patients admitted to St. Michael's Hospital. The pathway emphasized these primary objectives: medical and nursing addressing of primary health care issues and social work/discharge planning establishment, maintenance, and support of community links and addressing of psychosocial issues of these patients. The pathway was implemented in November 2001 for homeless patients admitted to General Internal Medicine. Retrospective chart audits were done in March 2002 to evaluate the effectiveness of the pathway, and a further evaluation was undertaken in August 2002.

Results

Data include demographics of patients identified on the pathway, including specific housing condition on admission. The poster illustrates comparative data on patients from the two evaluation periods after the implementation of the pathway. Examples of some of the clinical indicators to be evaluated include alcohol and substance abuse. The results are presented in a table form.

Conclusion

The use of an evidence-based clinical pathway for homeless and marginally housed patients admitted to the hospital is effective in raising awareness and addressing the primary health care and psychosocial needs of these unique patients.

A Volunteer Health Program for the Uninsured and Homeless in Scarborough, Canada

Paul G. Caulford, Cathy Tersigni, Jennifer D'Andrade, and Yasmin Vali
Department of Family Medicine and Community Services, Scarborough Hospital, ON, Canada

ABSTRACT

Objectives

The municipality of Scarborough, Ontario, Canada, receives one sixth of Canada's refugees and immigrants annually, more than any other municipality. Many of these new Cana-

dians arrive and live in the community without health insurance. The Department of Family Medicine and Community Services at the Scarborough Hospital sought to partner with other community health workers and agencies to establish a health program for the uninsured and homeless in Scarborough.

Methods

In September 1999, meetings were initiated between concerned community stakeholders and agencies and the Department of Family Medicine and Community Services to explore ways to provide no-cost/low-cost health care to the target population. In May 2000, a community-based volunteer health clinic program began providing health care to the uninsured and homeless.

Results

Two clinics continue to operate two evenings per week in the community, providing no-cost primary care. Each clinic is staffed by volunteers, including a receptionist, social worker, family physician, and public health/Community Care Access Centre nurse. A laboratory donated free blood work. There have been 2,150 patient visits in the first 2 years. Of these, 750 were discrete patients; the rest of the visits were repeat encounters. Of the patients, 90% meet the government criteria for homelessness. Reasons for not having Ontario Health Insurance Plan were 56% not eligible, 40% applied and waiting, out of province 1%, lost cards 2%, other 1%.

Patients were from 84 different countries of origin. The most represented countries/areas were India, Pakistan, Caribbean, and China at 10% each; Iraq, Iran, Bangladesh, and the Philippines at 5% each; Afghanistan, Ethiopia, Guyana, and Korea at 2% each.

Of the total discrete patient visits, 62% were women, 27% were under 19 years of age, and 14% were over age 60. Reasons for seeking health care were acute/chronic medical problems, 73%; pregnancy, 14%; immunization, 9%; infectious disease testing, 3%. Nearly 10% of patients required a consultant, and 30% received some form of diagnostic intervention.

Conclusions

Our data challenge the notion that Canada provides universally accessible health care to its communities. A significant number of new Canadians live and work without health insurance, supporting the need for more primary care capacity for this group. This population has significant unmet primary health needs. Women and children represent the two largest groups. There is a need for stable and sustainable pregnancy care. Almost half the patient load would be removed by expedited government issuance of health cards to those eligible and waiting.

Does Homelessness Correlate With Mental Illness?

Teresa Lapointe, Maureen Pennington, Evelyn Vingilis, and Larry Stitt
Lawson Research Institute, London, ON, Canada

ABSTRACT

Objectives

There has been a concerning increase in the number of homeless people in Ontario, Canada, in the last decade. Individuals with mental illness are identified as an underserviced subgroup of the population. Estimates of prevalence and severity of mental health problems among the homeless are limited and variable. Local point prevalence estimates should inform fiscal and community planning. In this paper, we report the point prevalence of mental illness in a sheltered male homeless population and suggest appropriate level-of-care placements.

Methods

The design was a cross-sectional survey. The homeless male population was defined as those men who lived in either of two male residential shelters in London, Ontario. A convenience sample of 70 men was interviewed, 35 from each shelter between January 2001 and July 2001. The instrument used was the Colorado Client Assessment Record (CCAR). The same interviewer, who received standardized training in CCAR administration, conducted all interviews. Completing a CCAR required approximately 1 hour.

Results

The point prevalence of mental illness was 80% in this male homeless population. In descending order, the diagnoses were substance-related disorders (46%), mood disorders (41%), schizophrenia and schizoaffective disorder (23%), anxiety disorders (16%), personality disorders (7%), and attention deficit disorder (3%). Over half the population assessed (61%) had one or more psychiatric disorders, excluding substance-related disorders. A total of 31% were diagnosed with a substance-related disorder and other psychiatric diagnoses. Two algorithms were used to assess level-of-care placements. Using the CCAR algorithm, 37.1% would require low levels of care, 54.3% would require moderate levels of care, and 8.6% would need high levels of care. Using the Clarke Institute Consulting Group template (1999), 34.3% would be able to self-manage, 22.9% would be better served with case management, 37.1% with intensive case management, 2.9% with residential treatment, and 2.9% with inpatient facilities.

Conclusions

This study identifies a needy population of homeless people suffering with mental illness. Institutional and community service providers struggle to provide appropriate levels of care. Prevalence studies may assist community and mental health planners to address the problems of a challenging population.

Health Status of Homeless Women: an Inventory of Issues and Future Initiatives

Patricia R. Petryshen and Judy Fiddes
Ontario Women's Health Council, ON, Canada

ABSTRACT

Objective

We aim to outline the demographic features of homeless women in Ontario, Canada; their unique health concerns; and the obstacles they encounter in accessing health services. It is intended to inform researchers, students, health and social service providers, and the public about health issues that homeless women face. The presentation also outlines some of the initiatives that the Ontario Women's Health Council has undertaken as part of its mandate to advocate for improvements in women's health.

Methods

An inventory of health-related issues was generated through a review of current literature and an environmental scan of some of the existing Ontario-based resources and services available to low-income, homeless, and socially isolated women.

Results

Data from shelters and other organizations in Toronto indicate that single women account for approximately 25% of the homeless population, of which three quarters have mental illnesses. Between 1992 and 1998, there was a 24% increase in shelter use among women with children. Together, single women and women with children comprise 29% of

shelter users. While less visible, homelessness is also a growing concern in rural areas. The scarcity of emergency shelters and other resources in small communities often forces women to move from one temporary housing arrangement to another.

While homeless women experience many of the same health problems as homeless men, they also face unique challenges. For instance, violence often precedes homelessness for women, and once homeless, violence continues and intensifies. Other health issues of particular significance to homeless women include family planning, pregnancy, breast and cervical cancer prevention, sexually transmitted infections, mental illness, and substance abuse.

A "think tank" of experts from across the province informed the council about the barriers that impair homeless women's access to health care services, including unavailable or fragmented services, no proof of health insurance, biases and misconceptions held by health care professionals, and competing priorities, such as securing food and shelter, which force health care to be assigned a lower level of importance.

Conclusions

Responding to the need for improved interventions, the council is supporting both research to identify innovative models of integrated and coordinated service delivery that address the health concerns of homeless women and the development of a standardized curriculum to better support health care professionals and others working with women living in poverty in the provision of more effective and responsive health care. We conclude by profiling these council-sponsored initiatives.

Drug Use and Health Risks in Toronto: the Need for Harm-Reduction Housing

Beric R. German

Street Health Community Nursing Foundation, Toronto, ON, Canada

ABSTRACT

Objectives

Illegal drug use by homeless and underhoused people in downtown Toronto, Ontario, Canada, was studied as it relates to the associated risk of contracting human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), hepatitis C, and other communicable diseases. As well, the connection was made between the lack of safe, secure housing as a major contributing factor to drug use itself and the resulting diseases. The study report makes recommendations regarding the need for appropriate housing for those most at risk for acquiring serious illnesses through their drug use.

Methods

A survey of 127 questions was developed and conducted with 136 illegal users who were homeless and underhoused. Answers were collated, and a report was written. Survey and subsequent recommendations were compiled by an advisory committee of community experts working in various ways with the study's target group.

Results

Through analysis of the data, HIV and hepatitis C infection rates among drug users were shown to be significantly higher than that of the general public. For instance, of the 82% who had been tested for hepatitis C, 46% tested positive. As well, of the 85% of participants who had been tested for HIV, 11.5% were positive. Among some of the alarming trends that emerged from the study results included that 57% of women and 21% of men had attempted suicide within their lifetime. Among other things, the study report recommends the establishment of a housing facility modeled after the Portland Hotel in Vancouver, Brit-

ish Columbia, which has been highly successful in improving the health status and stemming the spread of diseases such as HIV, hepatitis C, and tuberculosis among homeless people.

Conclusions

The report and accompanying recommendations provide a rare look at the relationship between the prerequisites of health, such as housing, and the spread of diseases among the homeless populations, particularly those who are long-term drug users. It is hoped that relevant policymakers and housing providers will give serious consideration to the study results, which indicate that lack of housing is a major contributor to the spread of debilitating, communicable disease among homeless drug users.

An Interactive, Web-Based Curriculum on Health Care Delivery to the Homeless

E. Maser, L. Petit, C. McLaughlin, and J. Turnbull
University of Toronto, ON, Canada

ABSTRACT

A Web-based interactive curriculum was developed in response to a need for improved delivery of health care to the homeless. The program highlights health problems common to the homeless. It also emphasizes unique "adverse determinants of health" that require consideration to plan successful treatment. Examples of adverse determinants of health include difficulty securing basic needs, unstable parenting, addictions, and mental illness.

The Health and Poverty Curriculum (HPC) is a Web-based resource designed to help medical students understand the diverse needs of the homeless. In this curriculum, first- and second-year medical students are presented with interactive problem-based case studies. Hypertext links provide access to questions, videos, and fact sheets that cover the following topics: alcoholism, drug abuse, trauma, infectious disease, cardiology, respirology, gastroenterology, mental health, women's health, youths, and international comparisons.

The learning objectives are (1) to identify health problems common to the homeless; (2) to recognize the unique factors in the lives of the homeless that complicate their access to the current health care system; (3) to adapt our health care practices to meet these unique needs; (4) to develop clinical decision-making skills and choose appropriate interventions relevant to the homeless; and (5) to participate in hypothetical hospital discharge planning and long-term management of homeless patients. Students receive audio and visual feedback as they answer questions in the case studies.

Recently, this curriculum has been incorporated into that of the University of Ottawa's medical school. In the future, the curriculum will be available globally to other health care professionals through the World Wide Web.

Finding the Heartfire: Spirituality in the Homeless in the Inner City

G. Malcolm Sinclair, John Joseph Mastandrea, and D. Linn Holness
Metropolitan United Church, Toronto, ON, Canada

ABSTRACT

Objectives

The purpose of this pilot work is to start to gain an understanding of spirituality in the lives of homeless individuals and its effect on their health. This will enable further work on this topic, which will then inform program development to address spiritual health issues in this group.

Methods

Two methods are being used. A literature review of spirituality and religion in disadvantaged/inner-city populations has been undertaken. A "gathering of common wisdom" is being held to explore spirituality and its influence on health in a group of homeless individuals who utilize the outreach programs of Metropolitan United Church, Toronto, Ontario, Canada. This gathering is being co-facilitated by the Rev. John Joseph Mastandrea and the Rev. Dr Malcolm Sinclair, ministers of the church with training and experience in issues of spiritual development. The conversation will be tape recorded, and written notes will also be taken. The participants will be advised of the confidentiality of the discussion and that they may choose not to answer any questions. Issues for exploration include the participants' sense of the Holy, Deity, or Spiritual Presence; how this was introduced or discovered by them; how it has developed or withered; what has happened to that sense over their years and in their circumstances. Do they have hope in such things now, and what does their spiritual hope, or lack of it, do to influence their health and well-being today? A similar gathering is being held with a control group.

Results

Although there is a large amount of literature on spirituality/religion and health, there is little information about this topic related to the homeless in the inner city. The results of the gatherings are presented.

Conclusions

This experience of gathering feelings and information will open the private, and even hidden, field of spiritual awareness among the homeless and will help inform the development of research questions to address spirituality and its influence on health in this group. This will also assist in the development of programs to address spiritual needs of inner-city homeless people from an overall health perspective.

Hepatitis and Homelessness in an Urban Health Center

Blair Pierce
University of Western Ontario, London, ON, Canada

ABSTRACT

Objectives

The proposed study has two phases. The purpose of phase 1 is to estimate the prevalence of hepatitis B, hepatitis B immunity, and hepatitis C. Also, phase 1 will permit testing the hypotheses that a history of incarceration, alcohol abuse, and injection drug use is associated with hepatitis B and C.

Phase 2 is to evaluate the effectiveness of a hepatitis B immunization program by measuring the seroconversion rate. The program will be offered to the nonimmune clients identified in phase 1.

Methods

Phase 1 is a descriptive clinical study using data collected by the nurses and family physicians when eligible patients present to the Health Outreach for Homeless Program. Phase 2 is a quasiexperimental descriptive study evaluating an immunization program for patients eligible for hepatitis B and revealing the conversion rate. No control group will be studied. Data will be collected on immunization forms in the patient's chart.

Results

Data collection is currently under way, starting May 2002; preliminary results will be available for presentation in October 2002.

Conclusions

Conclusions are presented based on the data as it becomes available.

Do Shelters for the Homeless in Toronto Provide Appropriate Menus for Those With Diabetes?

Naomi Ross, Diana Chislett, Stephen Hwang, Dana Whitham, Rhona Hanning, Karen Miller, and Pauline Darling

St Michael's Hospital and the Department of Nutritional Sciences, University of Toronto, ON, Canada

ABSTRACT

Objectives

A previous survey of homeless adults with diabetes in Toronto, Ontario, Canada, found that the diet at shelters was the most commonly reported barrier in managing their disease. Difficulties included inappropriate food choices for people with diabetes and lack of variety of food served. To further investigate these subjective reports of dietary problems, shelter menus were assessed for food group and nutrient composition, and the results were compared to Canada's Food Guide to Healthy Eating (CFGHE) and the Canadian Diabetes Association (CDA) Guidelines for the Nutritional Management of Diabetes Mellitus.

Methods

Directors from large homeless shelters in Toronto were surveyed to obtain information on the menus, menu planning, and opportunities for clients to make food choices. As well, direct observation of shelters at mealtime was used to compare menus to foods actually served and to verify portion sizes. For each shelter, menus for 3 days were entered into FoodSmart™ (Sasquatch Software Corporation) for analysis of food group and nutrient content.

Results

The largest men's shelters (n = 2) and women's shelters (n = 2) in Toronto operated on a 3–4-week menu cycle, served three meals and one snack per day in a cafeteria-style manner, and offered some opportunity for food choices. The actual meals observed at the shelters were onefold to twofold higher than menu portion sizes, accentuating the excess provision of added sugar, fat, and calories of menus relative to guidelines.

Guideline	Normal recommendation (per person, per day)	Range Provided by shelter menus (per person, per day)
CFGHE grain products	5–12 servings	5–14 servings
CFGHE vegetables and fruit	5–10 servings	4–13 servings
CFGHE meats and alternates	2–3 servings	1–4 servings
CFGHE milk products	2–4 servings	0.5–3.5 servings
CDA protein	12%–15% of energy	12%–14% of energy
CDA carbohydrates	50%–60% of energy	42%–57% of energy
CDA added sugars	≤10% of energy	11%–24% of energy
CDA total fat	≤30% of energy	31%–39%
CDA saturated fat	≤10% of energy	11%–12% of energy
CDA fiber	25–35 g	12–30g

In all shelters, the average daily energy content of menus exceeded the recommended nutrient intakes by 300–500 kcal/day.

Conclusions

In Toronto's largest homeless shelters, menus generally satisfy CFGHE guidelines, but are low in milk products. Improved nutritional quality of menus to reduce added sugars and saturated fat and to increase dietary fiber would better enable the homeless to manage their diabetes.

The Rotary Club of Toronto Infirmary in the Seaton House Annex Harm-Reduction Program: Piloting of a Patient Satisfaction Questionnaire

Agnieszka Kwasnicka and Tomislav Svoboda
St. Michael's Hospital, Toronto, ON, Canada

ABSTRACT

Objective

Our aim was a pilot study of a patient satisfaction questionnaire in an in-shelter infirmary for the homeless to determine its usefulness in this setting.

Methods

On November 5, 2001, the Rotary Club of Toronto Infirmary (RCTI), a 36 bed in-shelter unit for homeless men, opened in Toronto, Ontario, Canada. The RCTI is an expansion of the Seaton House Annex, a harm-reduction program and shelter in development by front-line staff since 1996. It includes a managed drinking program and a multidisciplinary approach with doctors, nurses, counselors, and shelter staff from Seaton House and St. Michael's Hospital. Clients are the high-risk homeless, a group with high rates of substance use problems, severe physical and mental illness, and behavior difficulties. Admission criteria include refusing hospital care against medical advice, requiring palliative care, suffering from acute illness or decompensation of chronic illness, or social problems.

The medical literature was reviewed and authors contacted to choose a patient satisfaction questionnaire based on reports of validity and reliability, wide use, anchoring in specific staff/program behaviors and activities, and ease of interpretation for program improvement. A modified version of the Picker Inpatient Patient Satisfaction Questionnaire was applied to all patients within 1 week of discharge and 3 months after the opening of the RCTI over a 7-week period. Informed consent was obtained by the interviewer, and a small honorarium

was given for study participation. Questionnaire results were categorized and analyzed according to dimensions of care defined in the Picker instrument.

Results

We approached 11 patients; 4 refused, 1 due to language barriers. Mean administration time was 35 minutes (20–78 minutes). Rates of clients reporting problems by dimension of care were as follows: involvement of family and friends (16.7% reported problems), respect for client preference (23.3%), overall impression (24.6%), coordination of care (30.8%), emotional support (35.4%), information and education (36.5%), physical comfort (57.9%), and continuity and transition (91.7%). The last two categories, which represent mainly pain management and care at time of discharge, were identified as areas in need of improvement. Clients' involvement in treatment decisions and their ability to get questions answered by nursing staff and to obtain emotional support from the doctor were also identified as potential areas needing improvement. Overall, the satisfaction score was similar to that of larger studies of hospitals in the United States and United Kingdom.

Conclusions

The Picker Questionnaire was found to be a useful tool in evaluating patient satisfaction in an in-shelter infirmary for high-risk homeless men.

Attitudes Toward Working With Marginalized Populations: a Case Study of Training in a Homeless Shelter Through St. Michael's Hospital

Jennifer McCabe, Tomislav Svoboda, and Philip Berger
St. Michael's Hospital, Toronto, ON, Canada

ABSTRACT

Objective

We aimed to explore the perceptions of medical students and family medicine resident following training experiences with marginalized men in the Annex Harm Reduction Program (HRP) and the Rotary Club of Toronto Infirmary (RCTI).

Methods

The Annex HRP and RCTI are in-shelter harm-reduction programs developed as a fusion of services between St. Michael's Hospital, an inner-city hospital, and Seaton House, a city-run shelter in collaboration with the University of Toronto, Ontario, Canada. The programs were designed to address calls for (1) improved hospital discharge planning, (2) harm-reduction programs, and (3) an infirmary for homeless by Toronto Public Health and the District Health Council and care for men with severe physical and mental illness, substance use, and behavior problems.

Questionnaires evaluating attitudes toward working with marginalized patients were filled out by students following training rotations. The Annex and RCTI questionnaires had similar questions and used 5-point Likert scales, from strongly disagree to strongly agree. All responses were kept confidential. Results were categorized by site of the rotation.

Results

Of 14 residents involved in the infirmary program, 6 responded to the questionnaire (response rate 42%). Of medical students involved in the clinic program, 8 completed the questionnaire (response rate 57%). Rates of agreement of students were as follows: useful educational experience (83% of residents), increased knowledge of inner-city health populations (67% of residents), was enjoyable (67% of residents), recommend to other students

(60% of residents), considering working with marginalized individuals (67% of residents and 88% of medical students), considering working with homeless (33% of residents and 75% of medical students), considering working with substance users (33% of residents), considering working with patients with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) (33% of residents), considering working with mentally ill (33% of residents), uncomfortable working with multisystem problems (17% of residents and 25% of medical students), unsatisfying to work with multisystem problems (33% of residents and 0% of medical students), and good sense of provision of health care to the marginalized (67% of residents). To determine if there was an effect of previous exposure to this type of work on response, we reviewed previous educational experiences. In 67% of residents and 88% of medical students, there were previous experiences in working with marginalized groups. In 67% of residents and 75% of medical students, there were previous experiences in working with the homeless.

Conclusion

The Seaton House programs were found to be enjoyable and helpful in increasing knowledge and comfort of working with marginalized persons.

The Annex Harm Reduction Program: Rates of Adherence and Hepatotoxicity Among Homeless Alcohol-Dependent Men Receiving Directly Observed Prophylactic Therapy During a Tuberculosis Outbreak

Tomislav Svoboda, Stephen Hwang, Karen Chien, and Jennifer Ross
St. Michael's Hospital, Toronto, ON, Canada

ABSTRACT

Objective

We aimed to evaluate compliance with directly observed prophylactic therapy (DOPT) and rates of hepatotoxicity in a group of homeless men who received treatment in an innovative harm-reduction program and shelter during a tuberculosis outbreak.

Methods

The Annex Harm Reduction Program is a shelter for chronically homeless men with high rates of substance use problems, severe physical and mental illness, and behavior difficulties. The program features a fusion of services between Seaton House, Canada's largest men's shelter, and St. Michael's Hospital, an inner-city teaching hospital in Toronto, Ontario, Canada. The multidisciplinary team approach includes nutrition, a managed drinking program (up to 1 drink/hour), primary health care, mental health care, hospital escorts, behavior stabilization, budgeting, and social work. Since January 2000, there have been 10 clients who have developed active respiratory tuberculosis with a single DNA-matched organism. All clients had chest X rays, tuberculin skin tests, and sputum cultures performed. Clients with positive skin tests not previously positive and who had no evidence of active disease were started on a DOPT regimen (isoniazid 900 mg two times per week for 6 months). Liver enzymes and function tests were measured at baseline, weekly in the first month, and then monthly unless indicated by new symptoms of confusion, nausea, or right upper quadrant pain. Hepatotoxicity was defined as liver enzymes that were five times normal or new symptoms as mentioned above accompanied by rising liver function tests. Clients were considered nonadherent if they discontinued DOPT for reasons other than hepatotoxicity or completing the 6-month course. Program staff estimated alcohol consumption based on knowledge of clients and review of program drinking logs. Drinking rates were independently estimated

by four staff and were averaged. Age, baseline aspartate aminotransferase (AST) and alanine aminotransferase (ALT), chronic treatment with liver-metabolized medications, and alcohol consumption were analyzed as predictors of hepatoxicity.

Results

Of 23 clients started on DOPT, 14 (61%) completed therapy, 9 (39%) stopped treatment due to hepatotoxicity, and none were nonadherent to DOPT. Nineteen clients (83%) drank alcohol daily, and 5 (22%) drank more than 10 drinks per day. Clients who drank more than 10 drinks per day were more likely to develop hepatotoxicity (odds ratio = 14.4, 95% confidence interval = 1.4, 150). In the literature, reported nonadherence rates among the homeless are 51%, 56%, and 80%.

Conclusions

Harm-reduction programming through a fusion of services between hospital and shelter show markedly higher rates of adherence among chronically homeless men with alcohol-related problems. High drinking rates are strongly associated with hepatotoxicity in this group.

Palliative Care and End-of-Life Care for High-Risk Homeless in the Annex Harm Reduction Program

Karen Smith, Tomislav Svoboda, and Art Manuel

Seaton House, City of Toronto, Shelter Housing Support Division, ON, Canada

ABSTRACT

Objectives

We aimed to describe the development of and experiences with a palliative care program as well as rates of end-of-life and palliative care provided in a harm-reduction shelter program for high-risk homeless men (those with severe physical and mental illness, behavior and substance use problems).

Methods

(1) The authors, senior staff involved in developing the Annex, described experiences with the development of end-of-life and palliative care in the Annex. (2) Shelter records were reviewed and staff interviewed to determine the number of clients who received end-of-life and palliative care, the number that died within 2 months of staying in the Annex, and causes of death.

Results

(1) The Annex Harm Reduction Program in Toronto, Ontario, Canada, is described in another abstract. Within 12 months of opening, three clients died on the Annex premises; two deaths were expected. Concerned about systemic barriers to services, front-line staff obtained city council approval for an in-shelter palliative care pilot program after much advocacy. The first palliative care client died in June 1998. Through a multidisciplinary fusion of services between Seaton House and St. Michael's Hospital, the program aims to allow clients to die in a supportive environment within their community of friends. Most clients have found the experience positive. Several clients have been distressed with fears of their own death. Family involvement increases with the palliative care process. Debriefing and group meetings increase staff and client awareness of the dying process. Challenges include increasing ongoing education and support for staff and clients unfamiliar with providing palliative care in a shelter setting. Improvements in the living will process include the need to use it earlier and more often and to anticipate conflicts between client care wishes

and desires for family decision making. In one case, a client's wishes conflicted with family wishes. Good staff-family rapport prior to the client's death allowed for a positive final outcome.

(2) In 5.5 years, the Annex cared for 469 clients; 49 have died (10%) while in or within 2 months of being in the program, 13 received end-of-life care, and 5 of these received palliative care. Common causes of death include alcohol-related liver and heart disease, respiratory infections, violence, and cancer.

Conclusions

The development of an innovative palliative care program for high-risk homeless is described. Experience has been positive, areas for improvement have been identified, and a formal evaluation is still needed.

Caring for the Caregivers: Occupational Health and Safety in Inner-City Workplaces

D. Linn Holness, Janet Gadeski, John Joseph Mastandrea, and G. Malcolm Sinclair

St. Michael's Hospital, University of Toronto, ON, Canada

ABSTRACT

Objectives

The objectives of this work were to (1) identify worker concerns in inner-city workplaces and (2) identify particular challenges in occupational health and safety (OHS) in inner-city workplaces.

Methods

Two methods were used. A survey of staff of St Michael's Hospital (SMH) in Toronto, Ontario, Canada, was conducted to determine staff perception of the importance of workplace hazards. A questionnaire was completed by 366 staff attending a health and safety exhibit; they rated the importance of 10 specified workplace hazards.

To identify particular challenges in OHS, we studied two organizations. SMH is a Catholic teaching hospital established to care for the sick and the poor of Toronto's inner city. It is dedicated to treating all with respect, compassion, and dignity and fosters healing and wholeness. SMH has an employee base of 4,600, over 600 physicians, 1,000 students, and 500 volunteers. Metropolitan United Church is an inner-city church with a vision that includes strengthening the compassion, commitment, and effectiveness of its social programs, which include a hostel, refugee center, and various food and clothing programs. It has approximately 30 staff and 300 volunteers.

Results

The percentage of SMH staff rating the various hazards as very important are as follows: infectious disease, 81%; safety (trips, falls), 74%; safety (workplace violence), 72%; stress, 69%; ergonomics, 62%; chemicals, 55%; and latex sensitivity, 35%.

In comparing OHS in the two organizations, we explored the tension between the vision/mission of caring for the disadvantaged on one hand and ensuring the safety and security of their communities on the other, and the large number of volunteer workers, who are not covered by occupational health and safety or workers' compensation legislation and who pose challenges with respect to training and supervision. Finally, the problems of program delivery for organizations with a small number of employees were identified.

Conclusions

There is little known about the unique challenges of OHS in inner-city organizations. An opportunity to research the workplace hazards in the inner city, the provision of OHS services in this setting with its unique challenges, and to determine which program models are most effective and allow mission-based organizations to carry out their healing ministry for inner-city people while providing a safe and healthy workplace environment for their communities exists.

The Development of a Homelessness Research Agenda: Lessons From the British Columbia Experience

James Frankish, Darryl Quantz, Susan Stevenson, and Sara Clemmer
Institute of Health Promotion Research, University of British Columbia, Vancouver, BC, Canada; Human Resources Development Canada

ABSTRACT

Objectives

This presentation reports on a project undertaken as a partnership between the University of British Columbia's Institute of Health Promotion Research, Human Resources Development Canada, and the Vancouver Regional Homelessness Research Committee. The objective of the project was to create an agenda for future homelessness research in the Greater Vancouver Regional District (GVRD). The final report outlined priority areas for research, issues regarding partnership and collaboration, and recommendations for increasing application of research.

Methods

The project compiled, reviewed, and synthesized current research on homelessness in the Greater Vancouver Regional District. Information was found in academic literature, conference proceedings, government publications and documents, program evaluations, and resources and documents from nonprofit organizations and government. Key informants participated by way of either a personal interview or a brief survey. This presentation reviews these results and presents them in the context of development of a collaborative research agenda. Data from a community forum are also included.

Results

Informants identified the role and implications of homelessness research within the context of their positions. Applications for research included program planning, funding, and information dissemination. Informants discussed perceptions of strengths and gaps within the homelessness literature. Finally, informants discussed the need for a collaborative approach among community, service providers, and government in planning and disseminating homelessness research.

Conclusions

The presentation uses homelessness research and its relations to determinants of health as a case to highlight shared understandings and experiences of community research. The community will use this information as a conceptual architecture and grounding for work on relations between homelessness and population health and stronger links among community research, policy, and practice. The presentation will provide a system for coding available homelessness research and a model for discussing the factors influencing the use of homelessness research in policy and practice.

Examining the Disparities in Health Status Between Housed and Homeless Canadians

Susan Farrell and Tim Aubry
Royal Ottawa Health Care Group and University of Ottawa, ON, Canada

ABSTRACT

Objective

We aimed to compare the health status of persons who are homeless in inner-city Ottawa, Ontario, Canada, with housed Canadians.

Methods

Information on health status and service utilization was collected from a randomly sampled group of 230 persons who are homeless (stratified into four groups defined by age and gender) and compared to the National Population Health Survey data collected from a panel study of 17,000 housed Canadians (Statistics Canada). The study also examined rates of mental illness and substance abuse (using population screening tools) in the homeless population.

Results

First, the methodology required to conduct research on health status with the inner-city homeless population is discussed. Strategies to address challenges and build community collaboration are reviewed. Second, the findings suggested higher rates of acute and chronic health conditions and rates of injuries and pain disorders for the homeless population. Higher rates of health care utilization (family physician) and inpatient services (hospital and convalescent care) were reported by the homeless population. Yet, despite high rates of service use, lower rates of quality of general health were reported and higher rates of experiencing barriers to health care services were found. Certain health care services (specialized physical care and mental health care) are difficult for the inner-city population to access, and they often do not provide a model of service that meets the needs and experiences of persons in the inner city. The experience of barriers by personal and systemic factors is reviewed. Incidence rates of mental health problems and substance abuse problems are reviewed, and rates of mental health problems were higher for females (adults higher than youths) than males. Rates of alcohol abuse were higher for males (youths higher than adults) than females, but drug abuse was higher for youths (both sexes) compared to adults. Higher rates of nicotine use for all homeless groups (as compared to housed Canadians) were reported.

Conclusions

The inner-city homeless population is at higher risk of health conditions (physical and mental) than housed Canadians. Despite high rates of use of some health care services, inequities and barriers to accessing quality care exist for the population. Challenges and lessons in both conducting inner-city research (to examine health status and unfulfilled health care needs) and planning responsive services are discussed. Implications of findings on planning for inner-city health care services in Ottawa are reviewed.